INTERIM STUDY COMMITTEE ON INSURANCE

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Authority: IC 2-5-33.3

MEETING MINUTES[1]

Meeting Date:	**September 25, 2012**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 233**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**2**

Members Present: **Rep. Matthew Lehman, Chairperson; Rep. Robert Heaton; Rep. Charlie Brown; Rep. Phil GiaQuinta; Sen. James Smith, Vice-Chairperson; Sen. Greg Taylor; Sen. Frank Mrvan.**

Members Absent: **Sen. Travis Holdman.**

Rep. Lehman called the meeting to order at 10:05 a.m. and noted that the previously planned lengthy meeting would be shortened because the data with which Rep. Lehman had expected to work during the meeting is not yet available. He stated that he would like to move the October 3, 2012, meeting to October 10, 2012. The Committee agreed to change the meeting to October 10, 2012, at 1:00 p.m.

Worker's Compensation Insurance in Indiana

Rep. Lehman explained that his plan for the Committee's work during this interim is to expand on the work done by the Committee during the last interim with respect to worker's compensation cost containment and benefits, particularly addressing difficulties with the current "percentile/geozip" method of determining provider payment rates, particularly for hospital payments. He noted that those issues, if not addressed, will eventually impact

[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

premium rates for worker's compensation insurance in Indiana. He mentioned that there are several possible payment rate determination methods that could be used, including: (1) the Medicare rate plus a percentage ("Medicare plus"); (2) commercial insurance rates; (3) a legislatively set maximum rate; and (4) a database of rates; and expressed his desire for the Committee to reach a consensus for a recommendation during the 2013 legislative session.

Ron Cooper, Indiana Compensation Rating Bureau (Bureau), described the history of the Bureau. He noted that there are currently 700 licensed worker's compensation insurers in Indiana, 280 of which are actively doing business in Indiana, which makes Indiana the third most represented state in the United States among worker's compensation insurers. Indiana also has one of the most stable worker's compensation systems in the country, according to Mr. Cooper.

Mr. Cooper stated that, unlike other states that sometimes completely overhaul their worker's compensation insurance systems to address problems, Indiana has a history of "tinkering" to adjust a mostly stable system. He noted the relatively stable rate adjustments which have remained in the single digits for almost a decade. He explained that 2010 was a "bad" worker's compensation year, likely related to the national recession, but that the system rebounded well in 2011, possibly related to a decrease in claim frequency that may have balanced the increased medical costs incurred in 2010.

Mr. Cooper reported that the Bureau is regulated by the Indiana Department of Insurance, and that the Bureau's "advisory" rates must be approved by the Department. He stated that the advisory rates are sometimes adopted for use by insurers or used by insurers as a basis for determining the insurers' own rates, which assists Indiana's competitive worker's compensation insurance market.

In response to questions from Rep. Brown, Mr. Cooper stated that:

> (1) A worker's compensation insurer may have several subsidiary companies licensed in Indiana, but choose to sell worker's compensation insurance through only a subset of those companies, which may account for the small number of insurers doing business in Indiana relative to the number of insurers licensed to do business in Indiana.
> (2) Approximately 75% of worker's compensation funds are expended for medical expenses and 25% expended for indemnity awards in Indiana. Throughout the United States the ratio is approximately 60/40. Higher worker's compensation medical expenses in Indiana may account for the difference.
> (3) Indiana worker's compensation claims are open for a shorter length of time than claims in other states, indicating that Indiana employees return to work more quickly.

Linda Hamilton, Chairperson, Indiana Worker's Compensation Board (Board), stated that the Worker's Compensation Research Institute is currently looking at the provider fees. She noted that:

> (1) The Board is considered to be the second most efficient worker's compensation board in the United States, with the second lowest cost of defending claims.
> (2) Indiana uses electronic filing of worker's compensation claims.
> (3) The average length of time that a worker's compensation case is open in Indiana is 1.33 to 1.55 years, while the national average is 2 years.
> (4) Indiana has experienced a decrease in the number of injuries from which work time is lost, but the claims for those injuries have increased.

(5) The Board becomes involved in a claim when the insurer and provider cannot settle the claim between themselves.
(6) Accuracy of hospital claim payment amounts is the main problem seen by the Board.
(7) The percentile/geozip method results in the providers with the eight lowest charges for a service being paid the amount charged and the two providers charging the most for the service are paid the amount of the eighth highest charge.
(8) The percentile/geozip method does not allow providers to know at what percentile they fall and so they do not know whether the amount paid is correct.
(9) Indiana's percentile/geozip statute refers to Current Procedural Terminology (CPT) codes (which are used by providers other than hospitals), rather than Diagnosis Related Group (DRG) codes (which are used by hospitals), so is not strictly applicable to hospital billing.
(10) Indiana has 160 hospitals, which is too few on which to apply the percentile/geozip method, regardless of Indiana's statute requiring it.
(11) A Medicare plus method would be beneficial as Medicare rates are publicly known and there would be no question about whether a payment is correct.
(12) Between 2002 and 2008 the median payment per claim for inpatient hospital care increased 93% in Indiana, compared with 54% nationally.
(13) Worker's compensation payments to providers other than hospitals grew more slowly between 2002 and 2008 because those providers monitor themselves and hospitals do not.
(14) Hospital charges are sometimes marked up as much as 600%, but since the percentile/geozip method does not work for hospitals, worker's compensation insurers must pay 100% of the amount charged, regardless of whether the amount charged is exhorbitant.
(15) Hospital charges for worker's compensation cases are the only medical charges in Indiana that must be paid at 100% because the percentile/geozip method does not work for the hospitals.

In response to questions from Rep. Brown, Rep. GiaQuinta, Sen. Smith, Sen. Taylor, and Rep. Lehman, Ms. Hamilton stated that:

(1) Because most large employers self insure worker's compensation and the Board never sees self insured claims, a comparison of large employer worker's compensation costs to those of small employers is not done by the Board.
(2) The average Indiana employer has 17 employees, so the Board would naturally see more claims from small employers.
(3) If there is not statistically significant data in a particular geozip area for a hospital, the area is expanded in an attempt to achieve statistical significance and use the percentile/geozip method. However, if statistical significance cannot be achieved, the Board will require payment of 100% of the charge, which leads to higher worker's compensation costs.
(4) Costs of hospital services are set by each hospital's "charge master", which may contain vast differences in cost even for hospitals that are geographically near to one another.
(5) Hospital service costs are contained in the "charge master", but actual hospital charges and payments for the services are established by proprietary contracts with third party payers, so comparative information of actual payment amounts is not available.
(6) Appeals to the Board occur because employees do not believe they are receiving the benefit to which they are entitled.
(7) Many states have adopted a Medicare plus payment method because it works, but the impact of such an adoption in Indiana on various parties would differ

depending on the manner in which the adoption was structured, such as whether adjustments to the payment schedule were dictated by statute or left for the Board to establish.
(8) Approximately 90% of appeals to the Board are from hospitals.

Tim Kennedy, Indiana Hospital Association (IHA), stated that the IHA supports worker's compensation program efficiency efforts and making benefits as appropriate as possible, "taking the mystery away". He acknowledged that providers and hospitals have a role in working toward this. Mr. Kennedy noted that statutory filing fees implemented two years ago have decreased the Board's docket considerably and that the fees penalize providers rather than insurers, even if insurer error turns out to be the reason for the appeal. He advocated scrutinizing all parties to worker's compensation claims, not just hospitals.

Rep. Lehman pointed out that hospital payment rates are being scrutinized because the problems experienced by the Board predominantly involve hospital payments.

Mr. Kennedy stated that:

(1) He has formed a task force of hospitals to look at the percentile/geozip method and that each geozip area contains at least ten hospitals.
(2) He believes that the main reason the current method does not work is that there is no reliable database for the geozip areas and that there may already be a reliable database available for use in Indiana, which the task force would like to investigate.
(3) A Medicare plus method may create a greater number of appeals due to coding issues and, according to the Kaiser Institute, the federal Affordable Care Act (ACA) will, over the next ten years, cost Indiana $3.8 billion in Medicare reimbursement, which needs to be considered in determining whether a Medicare plus method would be appropriate.
(4) Worker's compensation patients cost more than privately insured patients receiving the same services, so higher reimbursement than that received from a large commercial insurer (that has negotiated a volume discount with a provider) should be allowed for worker's compensation patients if a commercial insurance rate method is used.
(5) Everyone involved in worker's compensation insurance should be involved in the solution, not just hospitals.

In response to questions from Rep. Lehman, Rep. Brown, Sen. Smith, and Sen. Taylor, Mr. Kennedy stated that:

(1) It is possible that if a reliable database exists for use for hospital reimbursement, the percentile/geozip method may be workable.
(2) The IHA does not want to use commercial insurance rates as a basis for worker's compensation payment unless the additional costs of worker's compensation patients can be included in the calculation of the rate.
(3) The ACA was designed to result in insurance coverage for everyone, but it is not yet clear whether Indiana will participate in a Medicaid expansion, which removes some of the benefit of the ACA to hospitals.
(4) Charge masters are not secret as hospitals are required, according to strict standards under Medicare, to submit an annual cost report to the federal government, including uniformity of rates among payers.
(5) Charges must be the same for private payers and insurers, but contractual allowances from the charge master amounts may be granted to certain payers.
(6) Independent providers of services may charge less than the amount charged

for the same service at a hospital, but hospitals provide a broad spectrum of necessary services that are funded through those higher prices, i.e., a burn unit.
(7) He would recommend using the Healthy Indiana Plan for a Medicaid expansion in Indiana, but the federal Department of Health and Human Services may not allow that.

Marty Wood, Insurance Institute of Indiana, stated that lack of a database is not the main cause of problems with hospital payments by worker's compensation insurers. He expressed his opinion that coding does not work for hospitals because the percentile/geozip statute does not address DRGs and that the Medicare plus should be the method chosen with discussions centered on what the "plus" should be rather than the manner in which to change the percentile/geozip method. Mr. Wood stated that it must be determined: (1) whether there is an overpayment problem; (2) what amount is adequate for reimbursement; and (3) what the method should be to get to the adequate reimbursement amount for a service.

Mr. Wood noted that worker's compensation insurance payments for durable medical equipment should be determined through a separate "cost plus" method of reimbursement because the cost of the equipment is public information so accuracy of payment is easily determinable.

In response to questions from Rep. Lehman and Sen. Taylor, Mr. Wood stated that: (1) he is willing to work on determining whether to use commercial rates as a basis for reimbursement, but believes that Medicare plus would be most appropriate and close to commercial rates; (2) he would not agree with legislatively mandated loss ratios for worker's compensation insurers; and (3) he has not heard providers or others suggest using commercial rates or a willingness to disclose proprietary information, so he believes that Medicare plus is the most workable alternative.

Trevor Davis, Fair Pay Solutions, explained that Fair Pay Solutions is a "repricer" and provides repricing services in 45 jurisdictions by adapting payment information to state laws and informing payers about appropriate reimbursement in those jurisdictions.

In response to questions from Rep. Lehman, Mr. Davis stated that:

(1) If Indiana uses a Medicare plus method, Fair Pay Solutions would have a significant reduction in its work in Indiana.
(2) The percentile/geozip method is workable, but the current geographic areas are drawn too narrowly.
(3) Comparison to other providers is a necessary part of any payment system.
(4) 11 states use a Medicare plus method, 3 states use a commercial rate based method, and 1 state uses a database method, all of which are based not on charges but instead are based on payments.
(5) He would recommend a method based on payments for Indiana.
(6) He would urge the institution of a maximum amount that a payer would be required to pay for a service.

There was general discussion among the members concerning the approach of the Committee to its work for the interim. Rep. Lehman concluded the discussion by stating that the current worker's compensation insurance payment method should be replaced, and that Medicare plus and commercial rates are two viable options. He stated that the insurers and hospitals should come together to decide where to set reimbursements for hospitals. He requested that Mr. Kennedy and Mr. Wood bring information to the

Committee at the October 10, 2012, meeting on which the Committee may determine the direction it should take in making recommendations to the Legislative Council.

Mike Ripley, Indiana Chamber of Commerce, stated that the Chamber's members include both hospitals and employers and he would recommend a system that would move reimbursement as close to commercial rates as possible, beginning by obtaining the rates of Anthem and United because those are the two largest health insurers in Indiana. Mr. Ripley stated that increased benefits is another worker's compensation issue and that he would not be opposed to increasing benefits if it was accompanied by a net decrease in worker's compensation insurance rates.

In response to questions from Sen. Mrvan, Rep. Lehman, and Rep. Brown:

(1) Mr. Ripley agreed to provide information concerning worker's compensation benefits and costs in other states.
(2) Ms. Hamilton stated that Indiana's lost wage reimbursement is consistent with other states, but Indiana's indemnity benefit is in the bottom 1/3 to 1/4 of all states because the calculation has not been recently changed due to the poor economy.
(3) Mr. Cooper and Ms. Hamilton agreed to provide information comparing Indiana's wage replacement and permanent partial impairment benefits with other states.
(4) Ms. Hamilton stated that providers other than hospitals are open to another payment method, but are likely ambivalent because the current percentile/geozip method works for them.
(5) Mr. Ripley agreed to facilitate discussions between Mr. Kennedy and Mr. Wood (who each agreed to participate in the discussions) concerning a change to the payment determination method for hospitals and bring their recommendation to the Committee at the October 10, 2012, meeting.

With no further business to discuss, Rep. Lehman adjourned the meeting at 12:05 p.m.